DOCUMENT RESUME

ED 323 427 CG 022 749

AUTHOR Watson, Albert L.; Sayles-Folkes, Sherry L.
TITLE Culturally Sensitive Rehabilitation Counseling: Issues, Programs and Training.
PUB DATE 87
NOTE 24p.
PUB TYPE Guides - Non-Classroom Use (055)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Asian Americans; Blacks; *Counseling Services; Counselor Training; Cross Cultural Training; Cultural Differences; Delivery Systems; *Federal Programs; Hispanic Americans; Human Services; *Minority Groups; *Rehabilitation Counseling; Standards; *State Federal Aid; *Vocational Rehabilitation

ABSTRACT

This paper briefly summarizes differences reported in the service delivery provided by the State-Federal Vocational Rehabilitation (VR) service to minorities including Asian Americans, African Americans, Hispanics, and Native Americans. Unresolved issues which appear to influence the development and provision of culturally sensitive services are identified. These include issues of service delivery, policy making, training, and professional standards. Examples of culturally sensitive programs which may serve as models when developing culturally sensitive rehabilitation service are then provided. Rehabilitation counselor training, designed to produce culturally competent rehabilitation counselors who are needed to provide culturally sensitive services, are briefly discussed. References are included. (Author/TE)

**********
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
**********

ED323427

# Culturally Sensitive Rehabilitation Counseling: Issues, Programs and Training

Albert L. Watson

University of Cincinnati

Sherry L. Sayles-Folkes

Eastern Michigan University

CG 022749

Running Head: ISSUES, PROGRAMS AND TRAINING

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☑ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Albert L. Watson

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

Abstract

This paper briefly summarized differences reported in the service delivery provided by the State-Federal Vocational Rehabilitation (VR) service to minorities including Asian Americans, Blacks, Hispanics and Native American. Unresolved issues which appear to influence the development and provision of culturally sensitive services were identified. Examples of culturally sensitive programs which may serve as models when developing culturally sensitive rehabilitation service were provided. Rehabilitation counselor training, designed to produce culturally competent rehabilitation counselors who are needed to provide culturally sensitive services, was briefly discussed.

## Background

The need for effective rehabilitation services delivery for American minorities (i.e., Asian American, Blacks, Hispanics, and Native Americans) remains largely unmet. Although disportionately more minorities are disabled, utilization of the State-Federal Vocational Rehabilitation (VR) system by minorities is unexpectedly low. The percentage of work disabled Blacks 14% (Bowe, 1985) and Native Americans, 12.7% (Tanner & Martin, 1986) are nearly double that of whites, 8.5%. (Bowe, 1985b). Further most disabled Blacks and Hispanics of working age are women (Bowe, 1985a).

Various indicators of ineffective service delivery are reported. Acceptance rates into the VR services and rehabilitation rates are significantly lower for Native Americans then for the general caseload clients (Tanner and Martin, 1986). Hispanic clients were processed into the VR system more slowly than whites, relatively less time and materials were used to assess Hispanic clients, and Hispanic clients were less often rehabilitated (Riveria, 1986). Unequal treatment of Blacks in all dimensions of the public vocational rehabilitation including: (a) acceptance for VR service, (b) rate of successful rehabilitation, (c) level of income earned after rehabilitation

and (d) amount of training and education received are reported (Atkins and Wright, 1980).

Atkins & Wright (1980) suggest that problems experienced by disabled minorities may result from racial membership or associated disadvantaged i.e., a disproportionate number of Blacks clients were severely disabled, undereducated, chronic welfare recipients and otherwise culturally disadvantaged. It has been noted earlier that minority status in the VR system often refers not only to race and ethnicity, but to various types of disadvantagement including poverty, poor health, slum housing, discrimination, lack of organization and/or inadequate education (Raphael, 1972). Humphreyes & Provitt (1980) indicate Blacks are treated fairly in the VR system and disadvantages associated with being Black are the effects of experiences prior to entering the VR system.

Service delivery to the clients described ie., minority, poor, uneducated etc. may necessitate approaches other than the traditional services rendered. In fact, Katz (1985) described counseling as a socio-political act in that the foundations of counseling theory, practice, and research are comprised of values and beliefs of white middle class Americans. She contends that the use of traditional approaches with minorities may be viewed as a culturally insensitive practice ranging from a mild irritant to the client to a gross, offensive invasion into the

client's life. Beyond annoying the client, Raphael (1972) suggested that culturally encapsulated rehabilitation counselors are limited in the service they can provide. He indicates:

> While the aim is to provide a variety of evaluative, treatment, supportive, and developmental services leading to vocational rehabilitation, success is largely a product of the quality of interaction between client and counselor. These cultural differences are particularly important to counseling because much of the theory and process, and practitioners are products of the middle class culture. (p.34)

The authors assume that limitation of rehabilitation service delivery is due in part to a lack of programs which are attractive and culturally sensitive to Asian Americans, Blacks, Hispanics and Native Americans. Similar limitations have been widely acknowledged in the provision of both health and mental health services. (Copeland 1982, 1983; and Lum, 1986)

There are three major objectives in this paper. The first objective is to identify issues which directly or indirectly influence the availability of culturally sensitive rehabilitation programs. A clear articulation of these issues may aid rehabilitation professionals in reaching decision about future directions in service delivery, policy making, counselor training, and professional standards. A second objective is to

identify culturally sensitive programs which might be studied when developing VR programs for minority clients. A third objective is to explore strategies useful in training culturally competent rehabilitation counselors.

## Issues

Below is a list of unresolved issues related to cultural diversity and rehabilitation counseling. These issues are important to rehabilitation service providers, administrator, and counselor educators. The response to these issues by the rehabilitation profession, either reactive or proactive, tend to influence the planning, development and the effectiveness of rehabilitation service delivery to the minority disabled. The issues are categorized into four groups: (a) service delivery, (b) policy making, (c) training and (d) professional standard. An issue may be appropriate for more than one category. The issues, developed as a result of reviewing rehabilitation counseling literature, are offered as a focal point for further discussion and investigations.

### Service Delivery

1. Rehabilitation administrators and practitioners fail to develop effective strategies to (a) identify/solicit disabled minorities (b) provide culturally sensitive rehabilitation services and (c) to evaluate the effectiveness of service delivery.

2. Rehabilitation professionals fail to recognize the importance of informal support networks in the minority rehabilitant environment and incorporate them into the rehabilitation process.
3. The value of assessment procedures with disabled minorities has not been clarified and/or articulated, and remains a hinderance to effective rehabilitation service delivery.
4. There is minimal attention in Rehabilitation Counselor Education (RCE) or rehabilitation service delivery to the special issues of being in "multiple jeopardy" (i.e., disabled and minority, female, and/or elderly).

Policy Making

1. Policy makers, administrators, and practitioners do not recognize minority disabled as a priority group or provide "special services" to eleviate their disadvantaged status (e.g., lower educational level, higher incidence of severe disability) which presents an additional barrier to successful rehabilitation.
2. Minimal effort is placed on providing early and/or transitional services for minority disabled even though they tend to leave the educational system prematurely.
3. There is a lack of understanding of how resources (e.g. counselor) should be allocated to maximize the success rate of minority disabled.

4. There is an underrepresentation of minority administrators and counselors in the state-federal rehabilitation agency.
5. The rehabilitation agency milieu and environment (e.g., brochures, location) are often inconvenient and do not reflect the client's cultural background.

Training

1. There is a limited number of culturally competent rehabilitation counselors who are oriented to the special needs and circumstances of minority disabled.
2. Rehabilitation counselor education programs recognize the importance of cultural content in the RCE curriculum but do not provide adequate educational offerings in this area.

Professional Standards

1. Currently there is no clear statement of the actual or intended role of rehabilitation practitioners in the acculturation of disabled minorities.
2. There is a dearth of research on multicultural rehabilitation.

## Culturally Sensitive Programming

Although the State-Federal Rehabilitation Service is standardized throughout the country, use of the Individualized Written Rehabilitation Plan (IWRP) is a unique and intrical component of rehabilitation service programs. Due to the individualized nature of the IWRP, it permits a flexibility which

easily accommodates the cultural and individual differences among rehabilitation clients. (Riveria, 1983) Rehabilitation counselors who are culturally competent and skilled in maximizing the individualized nature of the IWRP are in a unique position to provide culturally sensitive rehabilitation services.

Current literature identifies various models or formats for developing culturally sensitive programs. Specific culturally sensitive programs have also been described. Below are examples of models with specific illustrations of selected culturally sensitive programs.

Culturally Sensitive Service Delivery Models

Roger, Malgady, Costantino, & Blumenthal (1987) identify three broad approaches to culturally sensitive mental health service which may serve as a means of structuring or categorizing culturally sensitive services. The three approaches include (a) rendering traditional treatment more accessible to minority clients; (b) selecting available therapeutic modalities which possess characteristics consistent with the minority culture of interest; and (c) extracting elements from the minority cultures and using them to modify traditional treatments or to create an innovative treatment strategies. The specific, culturally sensitive programs described below demonstrate how the approaches listed above have been incorporated into existing mental health and rehabilitation programs.

A second model of particular interest is that of Jones (1979). While many theorists have focused primarily on deficits or limitations of Blacks and other minorities, Jones has focused on the strengths or assets of Blacks. More than a mere acknowledgment of these assets, she explores procedures wherein they may be incorporated into the structure of service delivery. Jones identifies four positive characteristics of black families including: (1) strong kinship bond, (2) high achievement orientation, (3) strong work orientation, and (4) strong religious orientation. Incorporation of these strengths into service delivery, either individually or collectively, is believed to produce a culturally sensitive program which will result in culturally appropriate interventions and increased success among minority participants.

Galper (1978) differentiates between "traditional social services" where service providers consider society as fundamentally sound and ignore its destructive aspects as beyond the purview of the services from "radical social services" where social service providers view the source of the problems they address as deeply rooted in the social order and their work attempts to confront these problems at that level. Perhaps radical social services will be beneficial in serving the minority disabled, in that such an approach can provide culturally sensitive programming. Beyond providing needed

services, this approach can also effect social change to improve the quality of life of disabled minorities. Use of radical social services within minority communities in conjunction with traditional VR services may provide a unique benefit for minority disabled: a reduction in their level of disadvantage. This result, certainly, would contribute significantly to their successful rehabilitation.

Culturally Sensitive Programs and Strategies

More often cultural sensitive programs are provided in minority communities. Below are a sample of programs that have been developed. Some have been designed for Asian Americans, others for Hispanics, Blacks or Native Americans. The programs are categorized below by the group they serve.

Lum (1986) describes a program for Asian Americans, some of whom are developmentally disabled. The program incorporates various strategies in an effort to be responsive to cultural difference among clients. He indicates that the treatment approach is based on the development and enhancement of on-going communication with the Asian American communities. Lum (1986) explains that this process is facilitated through:

> utilizing staff who are primarily immigrants or refugees themselves (i.e., bilingual and bicultural); utilizing community leaders or youth peer leaders as volunteers wherever appropriate; undertaking periodic needs assessments

> and key informant interviews to keep abreast of changing needs; providing conflict mediation training to youth groups at local high schools; and, providing on-site counseling and guidance in local schools. (p. 31)

Chomori, Hatanaka, Higashioka, Uyekawa, Wakabayashi & Chan (1974) found that initial interviews with Asian American clients could be facilitated when held in a community setting which contained familiar elements such as bilingual literature, bilingual staffing, and respect for culturally familiar protocol. Recognition of these characteristics result in greater ability to attract Asian American clients.

Rogler, et al. (1987) in summarizing several culturally sensitive mental health programs designed for Hispanic clients indicates that the ability of the counselor and client to communicate in the same language provides the lowest common denominator of cultural sensitivity. Pape, Walker, & Quinn (1983) and Padilla, Ruiz, & Avarez (1975) recommend four specific strategies useful in recruiting disabled Hispanics to VR services: (a) bilingual staff, (b) use of interpreters as needed; (c) staff training in cultural sensitivity; and (d) use of extended family system to resolve conflict. Acosta & Cristo (1981) and Delgado (1982) reported using paraprofessionals from the client community as interpreters and cultural consultants. The cultural consultants help facilitate communication between

professional staff and Hispanic clients. Abad, Rames, & Boyce (1974) emphasize the importance of gaining support from the local religious and political leaders when developing mental health services in Hispanic communities. Use of specific strategies (e.g., use of bilingual/bicultural staff, integration of program into structure of the minority community, and coordination of program effort with needs of Hispanic community) resulted in more effective service delivery (Scott & Delgado, 1979).

Counseling theory is the guide to counseling practice, and Jereb (1982) indicates that the adequacy of most counseling theories in serving Black clients is questionable. Akber, 1977 and Allen (1978) described the incongruence between counseling practice and the Black experience, Black life style, and Black culture. A major limitation of traditional theories is the tendency to perceive various cultural aspects as deficient when in fact they are examples of strengths of the culture. Block (1979) indicates that white practitioners often overlook the effective coping mechanism demonstrated by Black clients. For example, she indicates that while the decision of a fourteen year old to carry through a pregnancy to term and keep the child may be "a poor decision" in the counselors opinion, it does indicate a strong sense of ability to cope with and master a hardship. "Similarly, the ability to deal with single parenthood, poverty and other environmental and social stresses is often an

indication of ego strength which should be noted" (Block, 1979, p. 189). Boyd (1977, cited in Block, 1979) suggest that other strengths of importance in assessing Black clients are quality and level of interpersonal or family relations, maintenance of strong support systems, and capacity to set and obtain goals.

Group work has been recognized as a very effective tool in assisting Black clients due to the similarity between group function and the Africentric disposition of Blacks (Shipp, 1983). Particularly attractive to Blacks is the familial image group process suggest which are consistent with the values Black clients place on family sharing and cooperation. Morales (1981) indicates that Third World individuals experience class discrimination and institutional racism. Therefore proactive intervention strategies are required.

Proactive services are recommended because they affect not only the individual but the group and the community. Three proactive strategies suggested were: (a) advocacy or pleading the cause of the minority person; (b) client empowerment such as assisting disenfranchised clients to develop skills in interpersonal influence and the performance of valued social roles; and (c) class action interventions such as, the collaboration between counselors and attorney to use the court system to stop social injustice. Grevious (1985) in a discussion of service delivery to low income Black families

recommended (a) receptionists that are congenial and courteous to minorities; (b) a waiting room with publications, pictures, toys and other artifacts which depict a Black theme; (c) providing an orientation to familiarize the client(s) to the expected role of both the counselor and the client(s); (d) out-of-office visits to observe the clients in their home; (e) use of paraprofessional and (f) use of other support systems in the clients community e.g., churches.

Training Culturally Competent Rehabilitation Counselors

Training issues identified earlier might be addressed by multicultural counselor training. Training culturally competent rehabilitation counselors is an essential step in developing culturally sensitive rehabilitation counselors and increasing the likelihood of culturally sensitive programming. Cultural competence consists of three components: (a) beliefs and attitudes which facilitate involvement, (b) knowledge of the clients culture and implications of the multicultural interaction, and (c) skill to select and use appropriate strategies in an appropriate manner. Various methods have been recommended including microcounseling (Ivey, 1971) and attribution training, sensitivity training and behavior modification (Triandis, 1977). Copeland (1983) identified four components which seem important in the development of culturally

competent counselors. They include: (a) consciousness raising, (b) cognitive understanding, (c) an affective component, and (d) skill development. Consciousness raising is designed to familiarize the counselor with a particular culture including both historical and current conditions. Pedersen's (1978) Triad Model offers an interesting approach to (a) identifying appropriate multicultural counseling skills, and (b) practicing developing, using, and modifying interventions.

Rehabilitation professionals, rehabilitation counselor educators and others were surveyed regarding the importance of cross-cultural content in the RCE curriculum (Watson, 1988). Results suggest that rehabilitation professionals recognize the importance of multicultural content in training rehabilitation professionals. Watson also identifies specific curriculum offerings which can be used as a guideline for rehabilitation counselor educators or trainers who choose to provide multicultural counselor training for rehabilitation professionals.

Watson & Kapadia (1988) describe didactic and experiential exercises recommended for training culturally competent rehabilitation counselors. They describe an example of a balanced multicultural rehabilitation counselor training effort which consists of: (a) twenty multicultural counseling competencies rehabilitation counselor educator might use as

training objectives; (b) twenty-six curriculum offerings instrumental in developing multicultural counseling competencies; and (c) a variety of experiential training methods valued in increasing multicultural awareness and sensitivity.

## Summary

Attention was directed at the differences in rehabilitation service delivery to Asian American, Black, Hispanic and Native American disabled. It is suggested that differences are due, in part, to the cultural insensitivity of the State-Federal VR System. Several issues were identified, and it was suggested that the consideration and eventual resolution of these issues will facilitate the development of culturally sensitive rehabilitation services and increase rehabilitation success rates among minorities.

Culturally sensitive programming was described regarding both general service delivery models as well as specific culturally sensitive programs and strategies. It was recommended that the models and programs described may encourage rehabilitation program development which is culturally appropriate. It is assumed that the skills, knowledge and attitudes of rehabilitation practitioners is a crucial aspect when developing and maintaining culturally sensitive rehabilitation services. Training approaches or strategies as well as curriculum content designed to develop culturally

competent rehabilitation counselors was summarized.

References

Abad, V., Ramas, J., & Boyce, C. (1974). A model for delivery of mental health services to Spanish-speaking minorities. American Journal of Orthopsychiatry, 44(4), 584-595.

Acosta, F., & Cristo, M. (1981). Development of a bilingual interpreter program: An alternative model for Spanish-speaking service. Professional Psychology, 12(4), 474-482.

Akbar, N (1977). Natural psychology and human transformation. Chicago: World Community of Islam.

Allen, W. (1978). The search for applicable theories for Black family. Journal of Marriage and the Family, 40(1), 117-129.

Atkins, B.J., & Wright, G.N. (1980). Vocational rehabilitation of black: Th statement. Journal of Rehabilitation, 46(2), 40-46.

Block, C.B. (1979). Black Americans and the cross-cultural counseling and psychotherapy experience. In A.J. Marsella and P.B. Pedersen (Eds.), Cross-cultural counseling and psychotherapy (pp. 177-194). New York: Pergamon Press.

Bolton, B., & Cooper, P.G. (1980). Vocational rehabilitation of blacks: The comment. Journal of Rehabilitation 46(2), 41-49.

Bowe, F. (1985a). Disabled adults of Hispanic origin: A statistical report drawn from census bureau data. Washington: DC. The President's Committee on Employment of the Handicapped.

Bowe, F. (1985b). Black adults with disabilities: A statistical report drawn from census bureau data. Washington: DC. The President's Committee on Employment of the Handicapped.

Chomori, K., Hatanaka, C., Higashiaka, C., Ishino, H., Sakamoto, K., Uyekawa, G., Wakabayashi, R., & Chan, S. (1974). Japanese American sightless institute project (Final Report). Washington, DC: U.S. Department of Health, Education, and Welfare, Social Rehabilitation Services.

Copeland, E.J. (1982). Minority populations and traditional counseling programs: Some alternatives. Counselor Education and Supervision, 21(3), 187-193.

Copeland, E.J. (1983). Cross-cultural counseling and psychotherapy: A historical perspective implications for research and training. The Personnel and Guidance Journal, 62(1), 10-15.

Delgado, M. (1982). Cultural consultation: Implications for hispanic mental health services in the United States. International Journal of Intercultural Relations, 6, 227-250.

Galper, J. (1978). What are radical social services? Social Policy, 1(1), 37-41.

Greviouis, C. (1985). The role of the family therapist with low-income black families. Family Therapy, 12(2), 115-122.

Humphreyes, R.R., & Provitt, E. (1980). Vocational rehabilitation of blacks: A response. Journal of Rehabilitation, 46(2), 41-46.

Ivey, A.E. (1971). Microcounseling innovations in interviewing training. Springfield, IL: Charles C. Thomas.

Jereb, R.J. (1982). Assessing the adequacy of counseling theories for use with black clients. Counseling and Values, 10, 17-26.

Jones, D.L. (1979). African-American clients: Clinical practice issues. Social Work, 24(1), 112-117.

Katz, J. (1985). The sociopolitical nature of counseling. The Counseling Psychologist, 13(4), 615-624.

Lum, R.G. (1986). Asian community mental health services. In M. Isaacs (Ed.), Developing mental health programs for minority youth and their families: A summary of conference proceedings (p. 31). Washington, DC: Georgetown University Child Development Center.

Morales, A. (1981). Social work with third-world people. Social Work, 26(1), 45-50.

Padilla, A., Ruiz, R.A., Avarez, R. (1975). community mental health services for the Spanish-speaking/surname population. American Psychologist, 30, 892-905.

Pape, D.A., Walker, G.R., & Quinn, F.H. (1983). Ethnicity and disability: Two minority statuses. Journal of Applied Rehabilitation Counseling, 14(4), 18-23.

Raphael, T.G. (1972). Rehabilitation of the disadvantaged. Journal of Rehabilitation, 3, 33-35.

Riveria, O.A. (1974). Vocational rehabilitation of disabled Chicanos (Doctral dissertation, University of Utah. Dissertation Abstracts International, 35, 2059-2060A. (University Microfilms No. 74-22, 707)

Riveria, O.A. (1983). The vocational rehabilitation process and Hispanic culture. In The special rehabilitation and research needs of disabled Hispanic persons. Edinburg, TX: Pan American University.

Rogler, L.H., Malgady, R.G., Costantino, G., & Blumenthal, R. (1987). What do culturally sensitive mental health services mean? The Case of hispanics. American Psychologist, 42(6), 565-570.

Skipp, P.L. (1983). Counseling blacks: A group approach. The Personnel and Guidance Journal, 62(2), 108-111.

Tanner, D.C., & Martin, W.E. (1986). Services and training needs in communicative problems and disorders for rehabilitation professionals serving Native Americans. Journal of Rehabilitation Administration, 11, 117-123.

Watson, A.L. (1988). Importance of cross-cultural counseling in rehabilitation counseling curricula. Manuscript submitted for publication.

Watson, A.L., & Kapadia, N. (1988). Experiential training to develop culturally competent counselors. Manuscript submitted for publication.